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STATE OF MISSOURI
DIVISION OF PROFESSIONAL REGISTRATION
POST-DEGREE SUPERVISION PLAN

MUST BE TYPED OR PRINTED LEGIBLY

INSTRUCTIONS **USE BLACK INK**

- This form MUST BE TYPED.
- Provide complete information. Incomplete information will delay your review.
- Sign and date the form.

Return form to:

State Committee of Psychologists
3605 Missouri Boulevard
Post Office Box 1335
Jefferson City, MO 65102-1335
Telephone (573) 751-0099
TDD 1-800-735-2966
e-mail: scop@pr.mo.gov

SECTION I – APPLICANT DATA – TO BE COMPLETED BY APPLICANT – MUST BE TYPED

1. NAME (FIRST, MIDDLE, MAIDEN, LAST)

SOCIAL SECURITY NUMBER

2. NAME (PROFESSIONAL NAME IF DIFFERENT FROM ABOVE)

3. ADDRESS (STREET, CITY, STATE, ZIP)

4. OFFICE PHONE

5. PSYCHOLOGY DEGREE RECEIVED FROM:

YEAR:

SECTION II – SUPERVISOR DATA – TO BE COMPLETED BY PRIMARY SUPERVISOR – MUST BE TYPED

6. NAME (FIRST, MIDDLE, MAIDEN, LAST)

7. E-MAIL

8. CURRENT OFFICE ADDRESS (STREET, CITY STATE, ZIP CODE)

9. TELEPHONE NUMBER

10. MAJOR AREA OF YOUR PROFESSIONAL WORK

☐ CLINICAL PSYCHOLOGY ☐ SCHOOL PSYCHOLOGY ☐ EVALUATIVE/APPLIED PSYCHOLOGY
☐ COUNSELING PSYCHOLOGY ☐ INDUSTRIAL/ORGANIZATIONAL PSYCH. ☐ OTHER

10. PLEASE CHECK ALL THAT APPLY

☐ ABPP DIPLOMATE ☐ APA MEMBER ☐ NATIONAL REGISTER PROVIDER
☐ APA FELLOW ☐ MO PSYCHOLOGICAL ASSN. FELLOW ☐ OTHER
☐ MO PSYCHOLOGICAL ASSN. MEMBER

11. ARE YOU A LICENSED PSYCHOLOGIST? ☐ YES ☐ NO

12. LIST ALL THE STATES IN WHICH YOU NOW HOLD OR HAVE EVER HELD A LICENSE/CERTIFICATE TO PRACTICE PSYCHOLOGY, IN ORDER OF ATTAINMENT. **IF NOT LICENSED IN MISSOURI, PLEASE ATTACH A PHOTOCOPY OF ALL CURRENT PSYCHOLOGY LICENSE(S) OR CERTIFICATE(S) WHICH CONTAIN AN EXPIRATION DATE.**

STATE	LICENSE/CERTIFICATE NUMBER	DATE OF ISSUANCE	CURRENT STATUS
A.			☐ ACTIVE ☐ INACTIVE ☐ OTHER
B.			☐ ACTIVE ☐ INACTIVE ☐ OTHER
C.			☐ ACTIVE ☐ INACTIVE ☐ OTHER
D.			☐ ACTIVE ☐ INACTIVE ☐ OTHER

13. LIST TITLES AND DEGREES YOU HELD DURING SUPERVISION OF THE APPLICANT.

TITLE	DEGREE	DATE REC'D	UNIVERSITY

14. ARE YOU A RELATIVE OF THE APPLICANT?
☐ YES ☐ NO

15. WILL AT LEAST ONE HOUR PER WEEK BE SPENT IN INDIVIDUAL, FACE-TO-FACE SUPERVISION?
☐ YES ☐ NO

16. WILL SUPERVISION OCCUR AT THE TRAINING SETTING? IF NO, EXPLAIN.
☐ YES ☐ NO

17. WILL CLIENTS BE ASSIGNED, PROGRESS MONITORED AND RESPONSIBILITY FOR THE CLIENTS BE ASSUMED BY YOU PERSONALLY?
☐ YES ☐ NO

18. WILL YOU REVIEW AND APPROVE TREATMENT NOTES AND CO-SIGN REPORTS? IF NO, EXPLAIN.
☐ YES ☐ NO

19. HAVE YOU REVIEWED THE APPLICANT'S EDUCATIONAL TRANSCRIPT AND EXPERIENCE?
☐ YES ☐ NO

20. WILL THE APPLICANT'S DUTIES BE APPROPRIATE TO HIS/HER GRADUATE EDUCATION AND TRAINING?
☐ YES ☐ NO

SECTION III – PROFESSIONAL SETTING – TO BE COMPLETED BY PRIMARY SUPERVISOR

21. NAME OF SETTING (WHERE SUPERVISED EXPERIENCE WILL OCCUR)

22. ADDRESS OF SETTING (STREET, CITY, STATE, ZIP)

23. TELEPHONE

24. THE ABOVE SETTING WOULD BE BEST DESCRIBED AS (CHECK ONE BOX):

☐ EDUCATIONAL COUNSELING CENTER ☐ MENTAL HEALTH CENTER ☐ EDUCATIONAL SETTING
☐ PRIVATE PRACTICE ☐ IN-PATIENT HOSPITAL ☐ RESIDENTIAL CENTER
☐ OUT-PATIENT OR DAY HOSPITAL ☐ OTHER _____

25. NUMBER OF EACH OF THE FOLLOWING LICENSED PROFESSIONALS EMPLOYED IN THIS SETTING:

____ PSYCHOLOGISTS ____ PROFESSIONAL COUNSELORS ____ OTHER
____ PSYCHIATRISTS ____ SOCIAL WORKERS _____
____ PHYSICIANS (NON PSYCHIATRISTS)

26. WILL THE APPLICANT CONSULT AND MEET WITH THE ABOVE PROFESSIONALS?
☐ YES ☐ NO

SECTION IV – SECONDARY SUPERVISOR DATA – TO BE COMPLETED BY SECONDARY SUPERVISOR – MUST BE TYPED

27. NAME (FIRST, MIDDLE, MAIDEN, LAST)

E-MAIL

28. CURRENT OFFICE ADDRESS (STREET, CITY STATE, ZIP CODE)

29. TELEPHONE NUMBER

30. MAJOR AREA OF YOUR PROFESSIONAL WORK

☐ CLINICAL PSYCHOLOGY ☐ SCHOOL PSYCHOLOGY ☐ EVALUATIVE/APPLIED PSYCHOLOGY
☐ COUNSELING PSYCHOLOGY ☐ INDUSTRIAL/ORGANIZATIONAL PSYCH. ☐ OTHER ▸

31. PLEASE CHECK ALL THAT APPLY

☐ ABPP DIPLOMATE ☐ APA MEMBER ☐ NATIONAL REGISTER PROVIDER
☐ APA FELLOW ☐ MO PSYCHOLOGICAL ASSN. FELLOW ☐ OTHER
☐ MO PSYCHOLOGICAL ASSN. MEMBER ▸

32. ARE YOU A LICENSED PSYCHOLOGIST? ☐ YES ☐ NO

33. LIST ALL THE STATES IN WHICH YOU NOW HOLD OR HAVE EVER HELD A LICENSE/CERTIFICATE TO PRACTICE PSYCHOLOGY, IN ORDER OF ATTAINMENT. **IF NOT LICENSED IN MISSOURI, PLEASE ATTACH A PHOTOCOPY OF ALL CURRENT PSYCHOLOGY LICENSE(S) OR CERTIFICATE(S) WHICH CONTAIN AN EXPIRATION DATE.**

STATE	LICENSE/CERTIFICATE NUMBER	DATE OF ISSUANCE	CURRENT STATUS
A.			☐ ACTIVE ☐ INACTIVE ☐ OTHER
B.			☐ ACTIVE ☐ INACTIVE ☐ OTHER
C.			☐ ACTIVE ☐ INACTIVE ☐ OTHER
D.			☐ ACTIVE ☐ INACTIVE ☐ OTHER

34. LIST TITLES AND DEGREES YOU HELD DURING SUPERVISION OF THE APPLICANT.

TITLE	DEGREE	DAE REC'D	UNIVERSITY

35. ARE YOU A RELATIVE OF THE APPLICANT?
☐ YES ☐ NO

36. WILL AT LEAST ONE HOUR PER WEEK BE SPENT IN INDIVIDUAL, FACE-TO-FACE SUPERVISION?
☐ YES ☐ NO

37. WILL SUPERVISION OCCUR AT THE TRAINING SETTING? IF NO, EXPLAIN.
☐ YES ☐ NO

38. WILL CLIENTS BE ASSIGNED, PROGRESS MONITORED AND RESPONSIBILITY FOR THE CLIENTS BE ASSUMED BY YOU PERSONALLY?
☐ YES ☐ NO

39. WILL YOU REVIEW AND APPROVE TREATMENT NOTES AND CO-SIGN REPORTS? IF NO, EXPLAIN.
☐ YES ☐ NO

40. HAVE YOU REVIEWED THE APPLICANT'S EDUCATIONAL TRANSCRIPT AND EXPERIENCE?
☐ YES ☐ NO

41. WILL THE APPLICANT'S DUTIES BE APPROPRIATE TO HIS/HER GRADUATE EDUCATION AND TRAINING?
☐ YES ☐ NO

SECTION V – PROFESSIONAL SETTING – TO BE COMPLETED BY SECONDARY SUPERVISOR

42. NAME OF SETTING (WHERE SUPERVISED EXPERIENCE WILL OCCUR)

43. ADDRESS OF SETTING (STREET, CITY, STATE, ZIP)

44. TELEPHONE

45. THE ABOVE SETTING WOULD BE BEST DESCRIBED AS (CHECK ONE BOX):

☐ EDUCATIONAL COUNSELING CENTER
☐ EDUCATIONAL SETTING
☐ IN-PATIENT HOSPITAL
☐ OUT-PATIENT OR DAY HOSPITAL
☐ MENTAL HEALTH CENTER
☐ PRIVATE PRACTICE
☐ RESIDENTIAL CENTER
☐ OTHER _____

46. NUMBER OF EACH OF THE FOLLOWING LICENSED PROFESSIONALS EMPLOYED IN THIS SETTING:

____ PSYCHOLOGISTS
____ PSYCHIATRISTS
____ PHYSICIANS (NON PSYCHIATRISTS)
____ PROFESSIONAL COUNSELORS
____ SOCIAL WORKERS
____ OTHER _____

47. WILL THE APPLICANT CONSULT AND MEET WITH THE ABOVE PROFESSIONALS?
☐ YES ☐ NO

SECTION VI – TO BE COMPLETED BY PRIMARY SUPERVISOR

48.

a. ☐ Yes ☐ No Are you employed at the training setting? If not employed, how are you affiliated with the setting?

_____

b. What is your official title at the setting? _____

c. How many hours per week are you on site at this setting? _____

d. Are you currently supervising other individuals for licensure purposes, including but not limited to psychology licensure?
☐ Yes ☐ No If yes, how many _____ psychology _____ other professions_____ profession type/s_____

SECTION VII – TO BE COMPLETED BY SECONDARY SUPERVISOR

49.

a. ☐ Yes ☐ No Are you employed at the training setting? If not employed, how are you affiliated with the setting?

_____

b. What is your official title at the setting? _____

c. How many hours per week are you on site at this setting? _____

d. Are you currently supervising other individuals for licensure purposes, including but not limited to psychology licensure?
☐ Yes ☐ No If yes, how many _____ psychology _____ other professions_____ profession type/s_____

SECTION VIII – TO BE COMPLETED BY APPLICANT

50.

a. ☐ Yes ☐ No Are you employed at the training setting? If not employed, how are you affiliated with the setting?

_____

b. Title you will hold at this setting? _____

c. How many hours per week are you on site at this setting? _____

51. DATE SUPERVISION BEGAN OR WILL BEGIN. THE NUMBER OF HOURS MUST MEET THE TOTAL NUMBER OF HOURS AS DOCUMENTED ON SECTION X (59).

52. DATE SUPERVISION WILL END

53.

a. ☐ Yes ☐ No Do you have administrative responsibilities or ownership interest in this setting? If yes, explain.

SECTION IX – SUPERVISED EXPERIENCE - TO BE COMPLETED BY PRIMARY SUPERVISOR WITH INPUT FROM ALL SECONDARY SUPERVISORS

54. DESCRIBE BRIEFLY THE NATURE OF THE TRAINING SETTING(S) WHERE SUPERVISION TOOK PLACE INCLUDING A BROCHURE, PAMPHLET, OR OTHER WRITTEN INFORMATION.

55. DESCRIBE TYPE OF CLIENTELE SEEN BY APPLICANT INCLUDING RANGE OF CLIENTS, NATURE OF PRESENTING PROBLEMS, DEMOGRAPHIC DATA, ETC.

56. DESCRIBE TYPES OF DIAGNOSTIC PROCEDURES, INTERVENTION ACTIVITIES AND THERAPEUTIC APPROACHES USED BY APPLICANT.

57. DATES OF SUPERVISION OF THE APPLICANT - PRIMARY SUPERVISOR

A. FROM MO DAY YR	TO MO DAY YR	**B.** FROM MO DAY YR	TO MO DAY YR	**C.** FROM MO DAY YR	TO MO DAY YR

58. DATES OF SUPERVISION OF THE APPLICANT - SECONDARY SUPERVISOR

A. FROM MO DAY YR	TO MO DAY YR	**B.** FROM MO DAY YR	TO MO DAY YR	**C.** FROM MO DAY YR	TO MO DAY YR

SECTION X

59. DESCRIBE THE VARIOUS PSYCHOLOGICAL ACTIVITIES TO BE PERFORMED AND EXPERIENCED DURING THE PERIOD OF SUPERVISION LISTED BELOW. SEE 20 CSR 2235-2.040(C) 1 E.

NOTE: Sections A-D Supervision must be a minimum of five (5) hours per week and must include at least three (3) of the four (4) categories.

	DESCRIPTION OF ACTIVITY	Minimum # of hours	Hours/week
A. Treatment team meeting with supervisor and other health professionals		2	
B. Didactic, Grand Rounds, Case Conferences, Lectures, Workshops, Seminars, and/or Peer Supervision.		1	
C. Readings from Books/Journals on psychological health services.		1	
D. Professional Activity. Development/Presentation of seminars, workshops, or lectures; Participation at Local, State, or National Meetings, Relevant Research; Teaching graduate/undergraduate courses; and/or Administration of delivery of psychological health services.		1	
E. Individual Face-to-Face Supervision		NEEDED 1	
F. Group Supervision			
G. Direct Client Contact		NEEDED 10	
H. Individual Psychotherapy			
I. Group Therapy			
J. Family Therapy			
K. Psychological Testing			
L. Other Psychological activities (Please specify)			
Total number of hours must meet the hours documented on Section VIII (50c)		**TOTAL**	

SECTION XI – SIGNATURES

60. ATTESTATION OF APPLICANT

I hereby affirm that the foregoing information which has been supplied is true and accurate to the best of my knowledge, information and belief. I further affirm that **if the supervision plan proposed is changed in any way, I will immediately notify the State Committee of Psychologists.**

SIGNATURE	DATE

61. ATTESTATION OF PRIMARY SUPERVISOR

I hereby affirm that the foregoing information which has been supplied is true and accurate to the best of my knowledge, information and belief. I further affirm that **if the supervision plan proposed is changed in any way, I will immediately notify the State Committee of Psychologists.**

SIGNATURE	DATE

62. ATTESTATION OF SECONDARY SUPERVISOR(S)

I hereby affirm that the foregoing information which has been supplied is true and accurate to the best of my knowledge, information and belief.

SIGNATURE	DATE
SIGNATURE	DATE
SIGNATURE	DATE